Ethical Issues in Family Practice

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INTRODUCTION

The Raison d'être principles in biomedical ethics have clearly become what are referred to as the four principles.[1] These can be summarized as the Principles of Beneficence, Nonmaleficence, Respect for Autonomy and Justice. A doctor has to do good whilst avoiding harm and at the same time respect the autonomous nature of the patient's wishes whilst keeping a balance with justice towards the patient and society in general. Although 'principlism', as the theory is often dubbed, has been shown to help us little in moral problem solving where dilemmas are concerned[2] such as whether to take one off a respirator or not, they are nevertheless useful guidelines in orienting one's thinking in the ethical process. Thus the four principles find a solid role in the teaching of ethics to health care professionals.[3] What is important is that these principles form part of the phenomenon of the doctor-patient relationship and that it is the *relationship* that concerns ethics more than a set of rules.[4] Thus more than being a 'code of ethics', the relationship is about the 'virtuous act'.[5] In this sense, truth telling is not merely a rule but is an ethical norm which should be imparted with compassion. This virtue is as important as the rule itself.[6]

Since the general practitioner (GP) is faced with long standing relationships these ethical standards are important in keeping the fiduciary and trusting nature of this human encounter.[7] Yet there are special ethical problems which come with a special emphasis on the family doctor.[8] This article reviews a few of these, referring to the Maltese situation in particular. Five areas of concern are discussed: the role of the GP in dual responsibilities, the role of the GP in Hospital, the role of the GP in issuing advanced directives, the problem of medical information, and specialized services offered by the GP.

DUAL RESPONSIBILITIES

There are a number of situations in which the general practitioner finds himself or herself where the loyalty is not imparted solely to the patient but also to some other body such as an employer, insurance or a medical board. In this situation the GP has a dual responsibility, the first to the patient and secondly to the body hiring the services of the doctor.[9] Thus in the case of doctors offering a verification of sick leave to an employer, the company doctor may be seen by the employer as serving a 'policing' role. Although the GP will hardly view himself as filling such a role, employees may often feel this to be the case when the GP is sent without their explicit consent. Although larger companies in Malta have collective agreements that specify that a doctor may be sent to the patient when sick, it is often the case that the doctor is sent even without the request of the employee. It is understood that the company doctor has a loyalty to the company in seeing that employees are in fact sick. Companies with collective agreements have at least conferred a message beforehand to the employees that a doctor will be sent. This is in contrast to a small business like a bakery calling in the private doctor of the owner because an employee is taking too much sick leave. Whilst the former situation is acceptable on grounds that it is a prior agreement, the latter is unacceptable as it is discriminatory and deliberately intended to 'catch' the person involved.

In all circumstances it is understood that the patient has a right to be examined by a doctor of his own choice.[10] Thus it is understandable that a woman, or even a man for that matter, may not want to be examined by a stranger with whom no sort of relationship as described above has been built. This has to be balanced against the risk the employee is taking vis-à-vis the employer if he or she refuses examination. Whilst this should be clearly explained at some stage of employment, any form of examination under the threat to one's employment is an act of coercion. This is a breach to the standard requirements of 'informed consent', a requisite of the principle of respect for autonomy.[11] This is a clear example why the ethics of medical care is based on the virtues of the doctor towards the patient, rather than simply a set of rules.

With respect to insurance, it is acceptable for the latter to assess the risk of the patient by having a knowledge of the patient's medical history, and that in order to do so the insurance employs its own doctor. It must be remembered however that in the course of the examination, if the doctor employed by the insurance or otherwise, discovers a medical fact, this information cannot be passed on to the insurance without the consent of the patient. It goes without say-

ing that without such consent the doctor may advise the insurance not to insure the patient but under no circumstances can he divulge information. This is not only in line with the confidentiality of the professional relationship but also because of the concept of 'ownership'; the patient 'owns' all medical information concerning his or her health whether this is written or kept on computer or otherwise.[12] This is discussed in more detail below. Genetic information cannot be sought for purposes other than for the health of the individual, according to the patient rights charter of the Council of Europe.[13] However, irrelevant genetic information which is known, such as carrier status for thalassaemia, need not be divulged to insurance as these do not constitute any risk. Genetic information is still controversial as a method of assessing risk. Even if one knows his or her genetic status, this may constitute a breach of one's right not to be discriminated against, if such information is given to insurance without it being balanced by seeking that information in all the pool of insured people; something which as yet is illegal and by ethical standards, considered immoral.

THE ROLE OF THE GP IN HOSPITAL

The GP has no official role in Maltese hospitals. This contrasts with certain countries like Canada where a Family Doctor participates in the management of his or her patients even in hospital. The role of the GP is basically reduced to writing a clear ticket of referral and when to refer the patient. Whilst a lot can be said about GP participation in secondary and tertiary care,[14] and about his or her role in participating in Advanced Directives[15] (prior expressed wishes of the patient such as not to resuscitate or organ donation), there is also much which hospitals can do to improve the continuity of care after the patient has been discharged from hospital.

Patients are often sent home without a discharge letter; which follows in the post a few weeks later. Whilst some specialties insist that a patient be given a discharge letter which includes even details of investigations carried out, other specialties send information through the post when it is practically useless for a GP who visits a patient a day or two after discharge from hospital. Although the workload of personnel is understandable and one need not compromise solidarity interprofessionally, the right to information should not be breached. A patient has a right to know all medical and surgical information upon discharge[16] and this should be put down immediately in writing for his or her right of continuity of care.

Patients should always be referred back to their general practitioner. Although this may be impossible in a system where there is no patient registration with individual or group GPs, this right should be respected. Often it is a GP who writes a ticket of referral, in which case the hospital administration should ask the patient whether they wish for him or her to be referred back to the doctor who sent the patient. It is understandable that many people 'shop around' with doctors, but most will have their personal family doctor to whom they would wish to be referred. Thus patients found to have a raised blood glucose may be sent to a health centre instead of their GP. It is the moral duty of GPs to act as patient advocates and speak out with autorities in order to provide optimal continuity of health care.

THE ADVANCED DIRECTIVE

Advanced directives are uncommon in Malta but have become important in western countries. An advanced directive is a directive which a patient gives in advance of an event and in view of such a time when he or she will be unable to express their voluntary wishes. Thus a person may wish to donate his organs but not his cornea. Another may want to be kept alive at all costs and never to be given a DNR order. Another may wish for his present wife to act as his surrogate and not his former wife or his children. All these requests should have legal means of being implemented. One way is by a notary, but a request made in front of a GP and signed by all counterparts should be morally binding, if not legal. Often hospitals will respect the wishes of the patient even in the absence of a document signed by a notary, once they can be reassured that the orders were in fact the wishes of the patient.

Conversely, GPs are often asked by relatives to issue certificates for elderly for the purposes of making out a will. It is obvious that the notary wants to be sure that the person is mentally capable of understanding a will. The GP must however beware of relatives who may wish to rush things for their interests. It is not the first time that these relatives call in their personal doctors instead of the actual doctor of the patient. Whilst it is assumed that even these doctors act in good faith, the doctor who has not known the elderly person before may not be in a position to assess whether in fact there is an element of coercion, even if the person passed the mental state examination. This is one reason why patients should be registered with doctors. Doctors may act as patient advocates and may be the only person acting in their interests in a particular situation. As things stand, if the family doctor

is not convinced that the person is capable of understanding what he or she is signing and that they are not being coerced, the family may seek another doctor who acting in good faith still certifies the person as capable of signing.

It goes without saying that it is unethical (if not illegal) for a GP to visit his or her patients in hospital for the purposes of making a mental assessment examination, without the consent of the hospital's superintendent and the consultant in charge of the patient. Such documents may probably be invalidated in a court of law if it is proved that the doctor had no authority to carry out an examination whilst the patient is under the care of another consultant. A doctor who is not participant in the management of the patient may not have a clear picture of what may be influencing the patient at the time of assessment (fever, medications, investigative procedures, anxiety etc).

OWNERSHIP OF INFORMATION

As has been said, the patient *owns* all information regarding his or her health. Whilst the problem with releasing information to insurance and employers has been discussed, two points which concern the GP are raised here. The first concerns truth telling. A patient always has a right to knowledge regarding his or her health. Thus a person may have been discharged from hospital with a diagnosis of cancer which the patient was not told about. It is the role of the GP to keep an ongoing lookout for whether, when and where the patient wants to be informed. Whilst it could be that the hospital team at the time thought it imprudent to inform the patient at that stage, once the patient is choosing the GP to participate in his or her continuity of care at home, the GP has an obligation to see whether the patient wants or should be informed about the illness. This should not be left merely at the discretion of the hospital follow-up. That a patient knows his condition may be important especially if he had to *refuse* certain treatment, which he would otherwise have accepted had he known about his diagnosis. Also the GP has a role in informing the hospital consultant should at any stage the patient express a wish *not to know* any details of the diagnosis. Moreover, although a patient has a right to confidentiality and thus to express a wish that his or her relatives not be informed of the diagnosis, a discussion with the GP may illuminate the individual that in his or her state, it is important for the people taking care of him to know about his condition. A relationship of trust and fidelity with the doctor may help the patient make these wise choices for his or her own well-being.

Second is the issue of parental rights. Young adults have a right to confidentiality as much as adults. Most courts will respect this right. The 'test case' in the United Kingdom was that of Mrs. Gillick who had challenged the health authorities not to give contraception or abortion advice or treatment to any of her daughters without parental consent.[17] Although she won the Court of Appeal, the House of Lords ruled against her and establish that young adults have the same rights as adults once it can be ascertained that they are capable of understanding and making choices. In fact, even children have a right to refuse information once they express this wish repeatedly over time and not merely out of fear and anxiety at the moment of treatment or examination.[18]

The GP has therefore the important role of guarding the confidentiality of young adults when parents call to enquire about why they visited the doctor or about the results of any investigations. One cannot assume that the children automatically want the parents to know. It would be prudent to ask them at an early stage whether they would allow or want the information to be divulged to the parents should the latter call out of worry or otherwise. Parents may feel they have a right to know information about their children, even when they are above legal adult age!

SPECIALISED SERVICES

GPs may offer specialised servies to patients in the form of treatments or investigative procedures. These may take the form of minor surgeries and ultrasound examinations, measurement of eye pressure etc. It goes without saying that no GP can perform any procedure without proper training; moreover all alternatives and choices have to be suggested to the patient. Many procedures such as minor surgery are justifiably done by a GP not only because it is within their specialty but also to save a considerable amount of time and money to the patient had the latter seek a specialist for the procedure. Conversely specialists may protest against the GP carrying out a specialized investigation such as an ultrasound.

That ultrasound is finding its way into General Practice is uncontested.[19] Yet there can be resistance to train GPs in the proper use of the machine. It is hoped that the newly formed Department of Family Medicine will have more to say about training GPs in diagnostic aids. An ultrasound is an extension of the stethoscope. Studies have shown that a physical examination in primary care aided by an ultrasound can detect at an early stage conditions such as thyroid tumours, abdominal aneurysms, cancer of the bladder and kidneys etc.[20] Whilst it is understandable that there may not be enough workload that radiogra-

phers request the help of primary care physicians, the issue is not about work log but about the ethics of a proper physical examination at primary care level. If it is proved that an ultrasound increases the chance of detecting conditions at an early stage, then the medical profession is morally bound to promote such an aid. Any detected pathology or questionable examination will have to be confirmed by a specialized radiographer at a later stage. This may increase referrals to specialist radiologists of pathology otherwise gone undetected. Yet for such tests to be carried out, GPs must undergo proper training. The weight of telling patients they have nothing is greater than when something, even if questionable, is detected.

CONCLUSION

Family practice undergoes changes along with medical technology. The GP must be informed of all changes and know when to refer a patient. The face of Family Medicine has increased in scope beyond the doctor with a bag. More than knowing a family over a span of time, the GP must be the patient's advocate in times of need such as when the latter cannot make decisions on his or her own any longer. Conversely the GP's surgery is turning into a family clinic which provides comprehensive primary care physical examinations and problem solving. It is for this reason that many prefer the term 'Family Physician' to 'General Practitioner', as attested by the change in the name of the American Academy of Family Physicians. There are other concerns which in Malta need further in-depth study. Such would be the case for talk on a comprehensive National Health Service or the cooperation between state and private primary care.[21] Conversely a number of issues have been discussed here which it is hoped will be taken up for debate by the Malta College of Family Doctors and the newly formed Department of Family Medicine within the Faculty of Medicine and Surgery. This is better than allowing things to metamorphose on their own, often in unethical and dangerous ways. Such is the case for ultrasound and minor surgery. Conversely, not catering for these expansions into our family practices is not only a disservice to our patients, it would be a lagging behind by pie-by-two behind international trends in family medicine.

ACKNOWLEDGEMENT

I would like to thank Dr. Denis Soler, President of the MCFD and Head of the Department of Family Medicine, for reading through this paper and for his kind encouragement and remarks.

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